MEDI-CAL UPDATE

Medical Services
Bulletin 353

Billing and Policy
Obstetrics Bulletin 353 **December 2003**

Contents

Articles with related Part 1 Manual Replacement Pages may be found in the "Program and Eligibility" bulletin. Articles with related Part 2 Manual Replacement Pages may be found in the "Billing and Policy" bulletin. The Medi-Cal Update *may not always contain a "Billing and Policy" section.*

Laboratory Service Reservation System (LSRS): New Frequency Limits

Effective for dates of service on or after January 5, 2004, laboratory services will be subject to new frequency limits. These limits are set per recipient, per service, per month. Using the new Laboratory Service Reservation System (LSRS), providers will be able to verify if a frequency limit has been reached on a specific recipient for a specific laboratory service prior to performing the procedure. If the frequency limit has not been reached, the system will reserve the service and issue a reservation number. If the frequency limit has been reached, the provider will receive immediate notification indicating that the recipient has received the maximum number of services allowed for the month of service.

Note: Frequency limits may be overridden on a case-by-case basis when medically justified and approved by medical review staff. Providers may be required to supply further documentation in support of medical justification for rendering the service.

Providers are not required to reserve laboratory services using the LSRS. However, previous claims for the same recipient and laboratory service may absorb all available reservations for the month, which would result in a denial for the claim submitted that exceeds the frequency limit. In order to avoid the possibility of having a claim denied because the frequency limit has been exceeded, providers may wish to use the LSRS to reserve a laboratory service prior to rendering the service. The Medi-Cal claims processing system will automatically reserve the service as the claim is processed if the provider does not reserve the service in advance – if a reservation is available.

Note: A claim denied because it exceeds frequency limits may be appealed.

The following laboratory service providers/entities are excluded from frequency limitations: End Stage Renal Disease (ESRD), county public health clinics, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disability Prevention (CHDP) Program, Skilled Nursing Facilities, inpatient hospitals and emergency rooms.

Please see **Laboratory**, *page 2*

Laboratory *(continued)*

Internet Availability
On January 5, 2004, the LSRS will be available on the Medi-Cal Web site at **www.medi-cal.ca.gov**. An e-learning tutorial will be available to guide providers through the LSRS process. In addition, provider training sessions will be scheduled for the months following implementation.

Providers without access to the Internet may call the Provider Support Center (PSC) at 1-800-541-5555. A call center representative will assist with the lab service reservation process.

More information about the LSRS will be published in a future *Medi-Cal Update*.

2004 HCPCS and CPT-4 Codes: Billing Update

The 2004 updates to the *Current Procedural Terminology – 4th Edition* (CPT-4) and *Healthcare Common Procedure Coding System* (HCPCS Level II codes) will become effective for Medicare on January 1, 2004. Medi-Cal has not yet adopted the 2004 updates. Do not use the 2004 code updates to bill for Medi-Cal services until notified to do so in a future *Medi-Cal Update*.

HCPCS/CPT-4 Code Updates: Modifications to Select Policies

Many of the medical and reimbursement policies for codes affected by the 2003 HCPCS/CPT-4 update were published in the September 2003 *Medi-Cal Update*. Additional policies are highlighted below. All information is effective for dates of service on or after September 22, 2003.

Laparoscopic Codes: Maximum Payment Reimbursement
Reimbursement for the following combination of laparoscopic/open procedure codes will be paid only up to the amount of the CPT-4 code with the highest maximum allowable amount if both are billed for the same date of service, any provider:

Laparoscopy Code	Open Procedure Code(s)
43651	64752, 64755 or 64760
43652	64755
50545	50230
55550	55530
58546	58146
58550	58260
58552	58262
58553	58290
58554	58291
58671	58615

Also, open surgical procedure codes for CPT-4 code 58545 (laparoscopy) were incorrectly listed in the September 2003 *Medi-Cal Update*. The correct combination is:

Laparoscopy Code	Open Procedure Code(s)
58545	58140 or 58145

Please see **HCPCS/CPT-4**, *page 3*

HCPCS/CPT-4 *(continued)*

Ultrasound Codes: Presumptive Eligibility
CPT-4 codes 76801, 76802, 76811, 76812 and 76817 (ultrasound) are reimbursable for Presumptive Eligibility services.

Laboratory Procedure Codes
In accordance with the 2003 CPT-4 update, an obstetrical panel (code 80055) is composed of only one combination of codes: 85025, 86592, 86762, 86850, 86900, 86901 and 87340. Reimbursement for separate billing of these seven component tests for the same recipient, same date of service, by the same provider will not exceed the rate for the obstetrical panel code 80055.

Total reimbursement of the individual "component" blood count codes, if billed separately by the same provider, for the same recipient, for the same date of service, will not exceed the reimbursement rate of the "complete" code for the following combinations:

Complete Code	Component Code(s)
85025	85004, 85014, 85018, 85027, 85041, 85048, 85049
85027	85014, 85018, 85041, 85048, 85049
85007 *	85008 *

* Priced the same; only one paid per date of service.

The updated information is reflected on manual replacement pages path hema 4 (Part 2) and path organ 6 (Part 2).

Medi-Cal Benefit List Changes
The following HCPCS codes are not Medi-Cal benefits: A4653, E0636, E1802 and S9145.

Radiological Ultrasounds: Frequency Limitations

Effective for dates of service on or after January 1, 2004, reimbursement for the following procedure codes is limited to four claims per year, for the same recipient, by any provider. Additional claims for these codes must be accompanied with appropriate medical justification or the claim will be denied.

CPT-4 Code	Description
76700	Ultrasound, abdominal, B-scan and/or real time with image documentation; complete
76705	limited (eg, single organ, quadrant, follow-up)
76770	Ultrasound, retroperitoneal (eg, renal, aorta, nodes), B-scan and/or real time with image documentation; complete
76775	limited

This information is reflected on manual replacement page radi 6 (Part 2).

CTP Services Payment Reduction

Effective for dates of service on or after January 1, 2004, reimbursements for Children's Treatment Program (CTP) services will be reduced by 5 percent. The reductions will remain in effect until further notice.

Although CTP services have been identified as exempt from the 5-percent Medi-Cal reimbursement reduction mandated under the Budget Act of 2003 (Assembly Bill 1762), projected CTP expenditures for the 2003-2004 fiscal year currently exceed revenues. Section 16934.5(b)(3)(c) of the *Welfare and Institutions Code* (W & I) states that the CTP may "…adjust payments for the remainder of the fiscal year to providers on a pro rata basis in order to ensure that expenditures do not exceed available revenues."

In addition, the reduction is consistent with the recent action by Medi-Cal to reduce provider reimbursements by 5 percent (refer to this month's Part 1 *Medi-Cal Update*). As stated in the *CTP Medical Services Policies and Procedures Manual*, "Reimbursement is provided at current Medi-Cal rates. (As Medi-Cal increases or reduces the level of reimbursement, CTP level of reimbursement will also change.)"

Other Contraceptive Supplies: Documenting 'At Cost' Expense and Reminder of Existing Policy

Medi-Cal policy requires providers to list items along with actual quantities in the *Reserved For Local Use* field (Box 19) of the claim or on an attachment when billing HCPCS code X1500 (other contraceptive supplies). Effective for dates of service on or after January 1, 2004, providers must also include the "at cost" expense in the *Reserved For Local Use* field (Box 19) or on an attachment. Claims submitted without this required documentation may be denied and will be subject to post-audit review. A billing example will be provided in a future *Medi-Cal Update*.

Refer to manual replacement page fam planning 9 (Part 2).

Contraceptive Supplies: Billing Reminder

Family PACT policy requires providers to document items, actual quantity and "at cost" expense in the *Reserved For Local Use* field (Box 19) when billing for code X1500 (other contraceptive supplies). Claims submitted without the required documentation may be denied and will be subject to post-audit review.

Replacement pages for the Family PACT *Policies, Procedures and Billing Instructions* (PPBI) manual will be issued in a future mailing to Family PACT providers. For more information regarding Family PACT, call the Provider Support Center (PSC) at 1-800-541-5555 from 8 a.m. to 5 p.m., Monday through Friday, except holidays.

Medi-Cal List of Contract Drugs: Updates

The following provider manual section has been updated: *Drugs: Contract Drugs List Part 1 – Prescription Drugs.*

Changes, effective December 1, 2003

Drug	Size and/or Strength
MORPHINE SULFATE	
*** Capsules, extended release**	**30 mg** **60 mg** **90 mg** **120 mg**
*** Restricted to a maximum of 90 capsules per dispensing and a maximum of three dispensings of any strength in a 75-day period. Exceptions to this restriction require prior authorization.**	
(NDC Labeler Code 64365 [Ligand Pharmaceuticals] only.)	
* Capsules, sustained release	20 mg 30 mg 50 mg 60 mg 100 mg
* Restricted to a maximum of 90 capsules per dispensing and a maximum of three dispensings of any strength in a 75-day period. Exceptions to this restriction require prior authorization.	
(NDC Labeler Code 63857 [Faulding Laboratories] only.)	
NORGESTIMATE AND ETHINYL ESTRADIOL	
Tablets from 7/7/7 combination packet (28 Tablets/packet)	7 x 0.180 mg/35 mcg 7 x 0.215 mg/35 mcg 7 x 0.250 mg/35 mcg 7 x inert
(NDC Labeler Code 00062 [Ortho Pharmaceutical Corporation] only.)	

Please see **Contract Drugs**, *page 6*

Contract Drugs *(continued)*

Changes, effective January 1, 2004

Drug	**Size and/or Strength**
***** CITALOPRAM HBR	
Tablets	20 mg
	40 mg
Solution	10 mg/5cc
*** Prior authorization always required.**	
LEVONORGESTREL AND ETHINYL ESTRADIOL	
Tablets from 6/5/10 combination packet (21 tablets/packet)	6 x 0.05 mg/30 mcg 5 x 0.075 mg/40 mcg 10 x 0.125 mg/30 mcg
(NDC labeler codes 00008 [Wyeth Laboratories] and 50419 [Berlex Laboratories, Inc.] only.)	
(28 tablets/packet)	6 x 0.05 mg/30 mcg 5 x 0.075 mg/40 mcg 10 x 0.125 mg/30 mcg 7 x inert
(NDC labeler codes 00008 [Wyeth Laboratories] and 50419 [Berlex Laboratories, Inc.] only.)	
NORGESTREL AND ETHINYL ESTRADIOL	
Tablets 0.3mg – 30 mcg	Tablets from 21 tablet packet Tablets from 28 tablet packet
0.5mg – 50 mcg	Tablets from 21 tablet packet Tablets from 28 tablet packet
(NDC Labeler Code 00008 [Wyeth Laboratories] only.)	

Provider Orientation and Update Sessions

The Family PACT (Planning, Access, Care and Treatment) Program was established in January 1997 to expand access to comprehensive family planning services for low-income California residents.

To be eligible to enroll as a medical provider in the Family PACT Program, the Medi-Cal provider seeking enrollment is required to attend a Provider Orientation and Update Session. When a group provider wishes to enroll, a physician-owner must attend the session. When a clinic wishes to enroll, the medical director or clinician responsible for oversight of the medical services rendered in connection with the Medi-Cal provider number is required to attend.

Office staff members, such as clinic managers and receptionists, are encouraged to attend but are not eligible to receive a *Certificate of Attendance*. Currently enrolled clinicians and staff are encouraged to attend to remain up to date with program policies and services.

Note: Medi-Cal laboratory and pharmacy providers are automatically eligible to participate in the Family PACT Program without attending an orientation session.

Dates and Locations
The following dates and locations are scheduled through April 2004:

January 14, 2004
Yuba City
Best Western Bonanza Inn
1001 Clark Avenue
Yuba City, CA 95991
For directions, call
(530) 674-8824

February 24, 2004
Anaheim
Radisson Hotel Maingate
1850 South Harbor Blvd
Anaheim, CA 92802
For directions, call
(714) 750-2801

March 9, 2004
Merced
Ramada Inn
2000 East Childs Avenue
Merced, CA 95340
For directions, call
(209) 723-3121

March 24, 2004
Bakersfield
Double Tree Hotel
3100 Camino Del Rio Court
Bakersfield, CA 93308
For directions, call
(661) 323-7111

April 21, 2004
Stockton
Courtyard by Marriott
3252 West March Lane
Stockton, CA 95219
For directions, call
(209) 472-9700

Check-in begins at 8 a.m. All orientation sessions start promptly at 8:30 a.m. and end by 4:30 p.m. The session covers Family PACT provider enrollment and responsibilities, client eligibility and enrollment, special scope of client services and benefits, provider resources and client education materials. This is not a billing seminar.

Provider Orientation and Update Session Registration
Providers should call the Center for Health Training at (510) 835-3795, ext. 113, to register for the session they plan to attend. Providers must supply the name of the Medi-Cal provider or facility, the Medi-Cal provider number, a contact telephone number, the anticipated number of people who will be attending and the location of the orientation session. At the session, providers must present their Medi-Cal provider number, medical license number and photo identification. Individuals representing a clinic or physician group should use the clinic or group Medi-Cal provider number, not the individual provider number or license number.

Please see **Family PACT**, *page 8*

Family PACT *(continued)*

Completing Provider Orientation and Update Session
Upon completion of the orientation session, each prospective new Family PACT medical provider will be mailed a *Certificate of Attendance*. Providers should include the white copy of the *Certificate of Attendance* when submitting the Family PACT application and agreement forms (available at the session) to Provider Enrollment Services.

Providers arriving late or leaving early will not be mailed a *Certificate of Attendance.* Currently enrolled Family PACT providers will not receive a certificate.

Family PACT Contact Information
For more information regarding the Family PACT Program, please call the Provider Support Center (PSC) at 1-800-541-5555 from 8 a.m. to 5 p.m., Monday through Friday, except holidays, or visit the Family PACT Web site at **www.familypact.org**.

ICD-9-CM Diagnosis Codes: 2004 Updates

Providers may use the following diagnosis codes for claims with dates of service on or after January 1, 2004. Please refer to the 2004 *International Classification of Diseases, 9th Revision, Clinical Modification, 6th Edition* (ICD-9-CM) for the description of each diagnosis code.

Additions

079.82	289.82	530.21	728.88	850.11	V53.91
255.10	289.89	530.85	752.81 *	850.12	V53.99
255.11	331.11 §§	600.00 *	752.89	959.11	V54.01
255.12	331.19	600.01 *	766.21 †	959.12	V54.02 §
255.13	331.82	600.10 *	766.22 †	959.13 *	V54.09
255.14	348.30	600.11 *	767.11 †	959.14	V58.63
277.81	348.31	600.20 *	767.19 †	959.19	V58.64
277.82	348.39	600.21 *	779.83 †	996.57	V58.65
277.83	358.00	600.90 *	780.93	V01.82	V64.41
277.84	358.01	600.91 *	780.94	V04.81	V64.42
277.89	414.07 +	607.85 *	781.94	V04.82 ††	V64.43
282.41	458.21	674.50 **	785.52	V04.89	V65.11 **‡
282.42	458.29	674.51 **	788.63	V15.87	V65.19
282.49	480.3	674.52 **	790.21	V25.03 **‡	V65.46
282.64	493.81	674.53 **	790.22	V43.21	E928.4
282.68	493.82	674.54 **	790.29	V43.22	E928.5
289.52	517.3	719.7	799.81 ‡‡	V45.85	
289.81	530.20	728.87	799.89	V53.90	

* Restricted to males
** Restricted to females
† Restricted to ages 0 thru 1 years
†† Restricted to ages 0 thru 3 years
§ Restricted to ages 0 thru 21 years
§§ Restricted to ages 0 thru 50 years
‡ Restricted to ages 5 thru 70 years
‡‡ Restricted to ages 10 thru 99 years
\+ Restricted to ages 40 thru 99 years

Please see **ICD-9**, *page 9*

ICD-9 *(continued)*

Revisions

The descriptions for the following ICD-9-CM diagnosis codes are revised: 282.60, 282.61, 282.62, 282.63, 282.69, 414.06, 491.20, 491.21, 493.00, 493.02, 493.10, 493.12, 493.20, 493.22, 493.90, 493.92, V06.1 and V06.5.

Inactive

Effective for dates of service on or after January 1, 2004, the following ICD-9-CM diagnosis codes are inactive and no longer reimbursable: 255.1, 277.8, 282.4, 289.8, 331.1, 348.3, 358.0, 458.2, 530.2, 600.0, 600.1, 600.2, 600.9, 719.70, 719.75, 719.76, 719.77, 719.78, 719.79, 752.8, 766.2, 767.1, 790.2, 799.8, 850.1, 959.1, V04.8, V43.2, V53.9, V54.0, V64.4 and V65.1.

Instructions for Manual Replacement Pages
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Part 2

Remove and replace forms at the end of the *Cancer Detection Programs: Every Woman Counts* section:	*Consent to Take Part in Program and Give Personal/Medical Facts* (form DHS 8478 [English]) * *Consent to Take Part in Program and Give Personal/Medical Facts* (form DHS 8478 [Spanish]) *
Remove and replace:	drug 3/4 * fam planning 9/10 non ph 9 thru 12 * path hema 3 thru 7 * path organ 5/6 * radi 5/6 tar sub clk 1/2 * tar submis 1/2 *

* Pages updated/corrected due to ongoing provider manual revisions.